A. To offer prompt, efficient, and competent services to the patients at all times.

B. To maintain sound departmental administrative policies and procedures.

C. To establish effective inter-departmental relationships.

D. To cooperate with the medical staff, administration, and all other departments in the Hospital.

E. To provide and maintain protective policies and measures for patients and personnel.

F. To provide good organization structure by assignment of specific duties, delegation of authority, and an efficient means of communication.

Attachments:

No Attachments

Approver	Date
Larry Corn: Director Laboratory	03/2013
Daniel Weaver, M.D.: Medical Director Laboratory	03/2013
John Dillon: Vice President Ambulatory Services	03/2013
Larry Corn: Director Laboratory	03/2015
Daniel Weaver, M.D.: Medical Director Laboratory	03/2015
John Dillon: Vice President Ambulatory Services	03/2015
Larry Corn: Director Laboratory	07/2015
Daniel Weaver, M.D.: Medical Director Laboratory	07/2015
John Dillon: Vice President Ambulatory Services	07/2015

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 17

POST ANESTHESIA CARE UNIT

1. List of Available Equipment in the PACU

Trauma Surgical Services-Operating Room, Staff and Equipment

Memorial Hospital and Health Care Center Surgical Services/Operating Room is committed to providing care to the injured patient by providing staff twenty four (24) hours a day. A call team is available with a 30 minute maximum response time during hours the Operating Room(OR) staff is not on site. Anesthesiologists are also in house or available with a 30 minute response time. Response times are monitored in the Performance Improvement and Patient Safety program:

The following equipment is available:

OR

Equipment	Infant	Child	Adult
Thermal control for patients and fluids/blood • Ranger Systems • Level One Systems • 6 ORS with fluid warmers-stocked daily w/LR and 0.9% NS • Bair huggers • Warm blankets • 6 K-pad units in Sterile Processing	X	X	X
X-ray capabilities including C-arm intensifier • C-arms with intensifier (2 OEC/GE) • Radiopaque tables	X	X	X
Rapid infuser system (e.g., pressure bag) • Have pressure bags (would not use on infants unless IO)	X	X	X

PACU

Equipment	Infant	Child	Adult
Equipment for monitoring and resuscitation • Broselow bag in PACU and Surgery Care • Crash cart from OR-immediately outside PACU door • Monitors ECG, BP, Pulse oximeter, A-line • Modules for ET CO2 (#2)-both NC and ET • Do NOT monitor ICP	X	X	X
Pulse oximetry • On each monitor	X	X	X

Thermal control for patients and fluids/blood • Ranger Systems • Level One Systems • 6 ORS with fluid warmers • Bair huggers • Warm blankets • 6 K-pad units in Sterile Processing CONCERN: may all be in use	X	X	X

Additional Equipment:

OR:

- Fracture tables (#2) for hip surgery
- Jackson table (#2) for tibia/femoral trauma
- Bronchoscopy and Endoscopy equipment in GI lab-can be done in OR in emergency situations
- Necessary equipment for fracture fixation

PACU:

- End-tidal CO2 monitors (2)
- Cardiac monitors with arterial monitoring capability

(Name)

Director Surgical Services Date: 07/16/15

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 18

RELATIONSHIP WITH AN ORGAN PROCUREMENT ORGANIZATION

1. Policy Regarding OPO Participation and Triggers for Notifying OPO

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Effective:	*09/1987*
Reviewed/Approved:	*02/2016*
Last Revised:	*02/2016*
Expires:	*02/2018*
Owner:	*Vicki Stuffle: Director Trauma Services*
Policy Area:	*Organizational*
References:	

Organ-Tissue Procurement

PURPOSE:

The purpose of this policy is to assist families, health care representatives, physicians and health care professionals to appropriately implement the right of each patient to choose both to have artificial support withdrawn and to donate their organs by establishing principles and procedures to be followed in these cases. Memorial Hospital and Health Care Center believes it is ethically appropriate to consider Donation after Cardiac Death (DCD). This policy is a reflection of our mission and values and places the highest emphasis on patient dignity and family support.

Federal regulation requires that hospitals request the consent of family members for organ, tissue, and eye donation following determination of imminent death or following the death of patients who are determined by the procurement agency (s) to be medically eligible for donation.

POLICY STATEMENT:

Memorial Hospital and Health Care Center in accordance with the Mission, Vision and values of Memorial Hospital and Health Care Center and the **Ethical and Religious Directives for Catholic Health Care Services** (2009), is firmly committed to the belief that each person is created by God in His own image and likeness and has been endowed with unique human dignity, rights and responsibilities. Memorial Hospital and its staff also firmly believe that the dignity and rights of each individual must be protected and promoted with the utmost care from the moment of conception throughout life, death and during the pre-procurement process involving anatomical gifts and the donor program.

GUIDELINES:

Memorial Hospital and Health Care Center will maintain a written contractual agreement for recovery services within the Organ Procurement Organization (OPO) federally designated for the Metropolitan Statistical Area (MSA) in which it is located. Additionally, the hospital will maintain a similar written agreement with at least one tissue bank and at least one eye bank operating in its geographical area that provides retrieval, processing, preservation, storage, and distribution services. Such agreements should not interfere with each other.

Before a family is approached about donation, the Hospital should contact the designated OPO to discuss the potential donor status of each patient with an appropriately trained medical professional for determination of medical suitability.

The Hospital recognizes the importance of allowing those who wish to donate the opportunity to do so in the hope that solace may be provided to the grieving family by their decision to participate in improving the quality of life for others. Additionally, we recognize each person as a unity of body, mind, and spirit who has been endowed with human dignity, rights, and responsibilities. And finally, the Hospital wishes to facilitate the donations of organs, tissues, and eyes in the broad interest of society and those awaiting transplantation, without infringing upon a family's deeply held beliefs, values, and rights.

The Hospital will work cooperatively with its designated OPO and contracted tissue and eye banks to educate its own staff on donation issues and on the maintenance of potential donor patients while necessary testing and placement of donated organs, tissues, and eyes take place.

The Hospital will simultaneously support the on-site efforts of recovery agency (s) staff who will work collaboratively with the Hospital's Medical Staff to secure medical consultations and laboratory studies necessary to determine the suitability of organs, tissues, and eyes for transplantation.

Lastly, the Hospital will allow and support any necessary patient medical record reviews requested by organ, tissue, and eye recovery agencies. Summary reporting from such reviews will be made available to appropriate regulatory and accrediting bodies for the purpose of illustrating compliance with the regulation.

FORM NEEDED:

Click here to access the "Organ, Tissue, & Eye Donation Authorization Form (NS 20)".

PROCEDURE:

Upon death of a patient in which cardiopulmonary death or clinical brain death (Reference Addendum A Guidelines for Determining Brain Death) has been declared, or death is imminent, (see Addendum B Clinical Triggers for Organ Donation) the following measures are implemented:

1. Call Indiana Donor Network at 1-800-356-7757 on EVERY DEATH prior to approaching the next-of-kin. The call should be made within one hour of death.
2. Receive authorization from the representative at Indiana Donor Network. Donors who are registered through the National web-based registry will be identified by the Coordinator.
3. Nursing staff may approach potential donor families and inform them of a phone call from American Donor Services or Indiana Lions Eye Bank to discuss organ/tissue donation. The nursing staff are not to obtain consent from the legal next-of-kin. This will be done by the representative of American Donor Services or Indiana Lions Eye Bank in the case of tissue procurement.
4. Provide information to the legal next-of-kin.
   A. Offer donation as an opportunity.
   B. DO NOT TRY TO CHANGE OPINIONS IF THE LEGAL NEXT-OF-KIN IS UNINTERESTED.
   C. Obtain telephone number of legal next-of-kin and inform them to expect a phone call from American Donor Services or Indiana Lions Eye Bank.
5. Contact the Coroner Office (if applicable).
   A. Inform the Coroner of the donor.
   B. Obtain the time that the autopsy will be performed (if applicable).

C. Obtain authorization to proceed with the donation before the autopsy. If the Coroner has questions the American Donor Services Transplant Coordinator should speak with him or her directly.

6. Call the appropriate funeral home (as per family wishes). NOTE: If the death occurs in the middle of the night you may decide to call the funeral home when the procurement is completed.
   A. Inform the funeral home of the procurement.
   B. Inform the American Donor Services and/or Indiana Lions Eye Bank of the funeral home name and phone number.
   C. Procurement will take place at the hospital or the funeral home, depending on the circumstances.
7. Continue with post mortem body preparation.
   A. To ensure that the eyes remain in good condition.
      1. Close them immediately after death.
      2. Elevate the head slightly.
      3. Place ice bags over the eyes.
8. Copy information from the patient's chart as requested by the Transplant Coordinator.

NOTE: After the patient is considered brain dead: (See Addendum A)

1. For organ preservation, the patient is maintained on the ventilator after the pronouncement of death, during which time care will continue to be given with respect and dignity.
2. The ventilator is disconnected in surgery following recovery of the organ (s).

NOTE: Indiana Organ Procurement Organization Manuals are available in the office of the House Supervisor, Critical Care Services, Surgical Services, and Emergency Services

DOCUMENTATION:

For brain death donation:

Document in the EMR:

1. Family education
2. Determination of brain death (date, time, and name of physician who made determination of brain death).
3. Completed consent form for organ donation and recovery
4. Complete donor record, including vital signs, assessments, treatment, and the clinical status of the donor.
5. Communication with the family with summary of information provided and response of the family.
6. Unexpected outcomes
7. Additional interventions

For donation after cardiac death (DCD):

Document in the EMR:

1. Family education

2. Family discussion and decision to discontinue life-sustaining procedures. Documentation must include the following:
    a. Date and time of discussion
    b. Name of legal next-of-kin's decision
    c. Responsible physician's signature
    d. Communication with the family with summary of information provided and response of the family.
3. The physician declaring (certifying) death will document the date and time of death in the patient's medical record and will complete the certificate of death.
4. Unexpected outcomes
5. Any additional interventions

For tissue and eye donation:

Document in the EMR:

1. Family education
2. Time of death
3. Tissue Procurement Notification and response
4. If appropriate, family approached and response
5. Transfer of body to funeral home
6. Any additional interventions

References:

donatelifeindiana.org

Indianadonornetwork.org

indianalionseyebank.org

americandonorservices.org

www.ismanet.org

Indiana Law Code / Statutes - See Addendum D

Addendum A

Indiana State Medical Association

Guidelines for Determining Brain Death

ADULT DIAGNOSTIC CRITERIA –
PATIENTS ABOVE 18 YEARS OF AGE

Diagnostic criteria for clinical diagnosis of brain death

A. Prerequisites. Brain death is the absence of clinical brain function when the proximate cause is known and demonstrably irreversible.

1. Clinical or neuroimaging evidence of an acute CNS catastrophe that is compatible with the clinical diagnosis of brain death
2. Exclusion of complicating medical conditions that may confound clinical assessment (no severe electrolyte, acid-base, or endocrine disturbance)
3. No drug intoxication or poisoning
4. Core temperature ≥32 ° C (90 ° F)

B. The three cardinal findings in brain death are coma or unresponsiveness, absence of brainstem reflexes, and apnea.

1. Coma or unreponsiveness - no cerebral motor response to pain in all extremities (nail-bed pressure and supraorbital pressure)
2. Absence of brainstem reflexes
   a. Pupils
      i. No response to bright light
      ii. Size: midposition (4mm) to dilated (9mm)
   b. Ocular movement
      i. No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)
      ii. No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side)
   c. Facial sensation and facial motor response
      i. No corneal reflex to touch with a throat swab
      ii. No jaw reflex
      iii. No grimacing to deep pressure on nail bed, supraorbital ridge, or temporomandibular joint
   d. Pharyngeal and tracheal reflexes
      i. a. No response after stimulation of the posterior pharynx with tongue blade
         b. No cough response to bronchial suctioning
3. Apnea – testing performed as follows:
   a. Prerequisites
      i. Core temperature ≥ 36.5°C or 97° F
      ii. Systolic blood pressure ≥ 90 mm Hg
      iii. Euvolemia. *Option:* positive fluid balance in the previous 6 hours
      iv. Normal PCO_2. *Option:* arterial $PCO_2 \geq 40$ mm Hg
      v. Normal PO_2. *Option:* preoxygenation to obtain arterial $PO_2 \geq 200$ mm Hg

b. Connect a pulse oximeter and disconnect the ventilator.

c. Deliver 100% O_2, 6 1/min, into the trachea. *Option:* place a cannula at the level of the carina.

d. Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes).

e. Measure arterial PO_2, PCO_2 and pH after approximately 8 minutes and reconnect the ventilator.

f. If respiratory movements are absent and arterial PCO_2 is ≥ 60 mm Hg (*option:* 20 mm Hg increase in PCO_2 over a baseline normal PCO_2), the apnea test result is positive (i.e., it supports the diagnosis of brain death).

g. If respiratory movements are observed, the apnea test result is negative (i.e., it does not support the clinical diagnosis of brain death), and the test should be repeated.

h. Connect the ventilator if, during testing, the systolic blood pressure becomes ≤ 90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial blood sample and analyze arterial blood gas. If PCO_2 is ≥ 60 mm Hg or PCO_2 increase is ≥ 20 mm Hg over baseline normal PCO_2, the apnea test result is positive (it supports the clinical diagnosis of brain death); if PCO_2 is < 60 mm Hg or PCO_2 increase is < 20 mm Hg over baseline normal PCO_2, the result is indeterminate, and an additional confirmatory test can be considered.

Pitfalls in the diagnosis of brain death

The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made with certainty on clinical grounds alone. Confirmatory tests are recommended.

A. Severe facial trauma

B. Preexisting pupillary abnormalities

C. Toxic levels of any sedative drugs, aminoglycosides, tricyclic antidepressants, anticholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents

D. Sleep apnea or severe pulmonary disease resulting in chronic retention of CO_2.

E. Pregnancy is a special situation.

Clinical observations compatible with the diagnosis of brain death

These manifestations are occasionally seen and should not be misinterpreted as evidence for brainstem function.

A. Spontaneous movements of limbs other than pathologic flexion or extension response.

B. Respiratory-like movements (shoulder elevation and adduction, back arching, intercostals expansion without significant tidal volumes)

C. Sweating, blushing, tachycardia

D. Normal blood pressure without pharmacologic support or sudden increases in blood pressure

E. Absence of diabetes insipidus

F. Deep tendon reflexes; superficial abdominal reflexes; triple flexion response

G. Babinski reflex

Confirmatory laboratory tests (*Options*)

Brain death is a clinical diagnosis. A repeat clinical evaluation 6 hours later is recommended but this interval is arbitrary. A confirmatory test is not mandatory but is desirable in patients in whom specific components of clinical testing cannot be reliably performed or evaluated. It should be emphasized that any of the suggested confirmatory tests may produce similar results in patients with catastrophic brain damage who do not (yet) fulfill the clinical criteria of brain death. The following confirmatory test findings are listed in the order of the most definitive test first. Consensus criteria are identified by individual tests.

A. Conventional angiography. No intracerebral filling at the level of the carotid birfurcation or circle of Willis. The external carotid circulation is patent, and filling of the superior longitudinal sinus may be delayed.

B. Electroencephalography. No electrical activity during at least 30 minutes of recording that adheres to the minimal technical criteria for EEG recording in suspected brain death as adopted by the American Electroencephalographic Society, including 16-channel EEG instruments.

C. Transcranial Doppler ultrasonography

   1. Ten percent of patients may not have temporal insonation windows. Therefore, the initial absence of Doppler signals cannot be interpreted as consistent with brain death.

   2. Small systolic peaks in early systole without diastolic flow or reverberating flow, indicating very high vascular resistance associated with greatly increased intracranial pressure.

D. Technetium 99m hexamethylpropyleneamineoxime (HMPAO or Ceretec) or technetium 99m (ethyl cysteinate dimmer (ECD, bicasate or neurolite) brain profusion scintigraphy, otherwise known as isotope flow study with brain scan. No flow to brain and no uptake of isotope in brain parenchyma (hollow skull phenomenon) is consistent with brain death.

E. Somatosensory evoked potentials. Bilateral absence of N20-P22 response with median nerve stimulation. The recordings should adhere to the minimal technical criteria for somatosensory evoked potential recording in suspected brain death as adopted by the American Electroencephalographic Society.

Medical record documentation *(Standard)*

A. Etiology and irreversibility of condition

B. Absence of brainstem reflexes

C. Absence of motor response to pain

D. Absence of respiration with PCO_2, ≥ 60 mm Hg

E. Justification for confirmatory test and result of confirmatory test

F. Optional: Repeat neurologic examination. The interval is arbitrary, but a 6-hour period is reasonable.

G. Document repeat neurological examination if performed.

ADDENDUM B

Clinical Triggers for Organ Donation

1. Vented patient with Glasgow Coma Scale of 5 or less
2. Before any terminal wean, call Indiana Donor Network at the first mention from physician or family

Reminder: Cardiac time of death must be called even if you called with the above triggers.

Call Indiana Donor Network: 1-800-356-7757

ADDENDUM C

DEFINITIONS:

Death: Individual who has sustained irreversible cessation of all circulatory and respiratory function.

Brain Death: Individual who has a sustained irreversible cessation of all functions of the entire brain, including the brain stem.

Imminent Death: individual who has a condition, due to his or her injury, disease or illness, from which, with a reasonable degree of medical certainty, there can be no recovery and that death will occur within a short period of time without instituting life-prolonging procedures. If death is imminent, the Indiana Donor Network will be contacted prior to the removal of any mechanical/artificial support or discussion with the family about the removal of life support, for any brain-injured or vented patient and patients with a Glasgow Coma Scale (GCS) of 5 or less (see Addendum A).

Reportable Death: Deaths requiring a death certificate or fetal death certificate as required by Indiana State Department of Health. No reporting is required for abortions, miscarriages or fetal deaths less than 20 weeks gestation.

Organ Donation: Donation of solid organs which includes heart, lungs, liver, kidneys, pancreas and small intestines from an individual who is brain dead but whose heart is beating due to a mechanical-support device or donor-after cardiac death (DCD).

Donation after cardiac death (DCD): Organ recovery from patients who do not meet the brain death criteria, but are pronounced dead on the basis of irreversible cessation of circulatory and respiratory function.

Tissue donation: Donation of tissues, which includes heart valves, veins, arteries, tendons, ligaments, bone, fascia, skin, corneas, whole eyes and neonatal kidneys from an individual whose heart is no longer beating.

ADDENDUM D

Indiana Law

Ind. Code § 1-1-4-3 : Indiana Code - Section 1-1-4-3: Uniform Determination of Death Act

Ind. Code § 29-2-16.1-7 : Indiana Code - Section 29-2-16.1-7: Persons prohibited from making, amending, or revoking an anatomical gift; donor revocation of an anatomical gift; unemancipated minors

Ind. Code § 29-2-16.1-8 : Indiana Code - Section 29-2-16.1-8: Priority of persons authorized to make an anatomical gift of a decedent's body or part

Ind. Code § 36-2-14-22.4 : Indiana Code - Section 36-2-14-22.4: Organ and tissue procurement

Ind. Code § 36-2-14-22.6 : Indiana Code - Section 36-2-14-22.6: Information requests; medicolegal examinations; interference with postmortem examinations; denial of recovery

Ind. Code § 29-2-16.1-21 : Indiana Code - Section 29-2-16.1-21: Coroner cooperation with procurement organizations; postmortem examinations; removal of a part of organ from a decedent

ADDENDUM E

Indiana Organ Procurement Organization (IOPO)

Recitals Describing the Organ Procurement Process in an Indiana Hospital:

A. IOPO is an Indiana nonprofit corporation and is a freestanding Organ procurement organization (within the meaning of 42 C.F.R. § 413.200 and § 486.302) which is the federally qualified Organ procurement organization designated for the donation service area within the State of Indiana in accordance with Section 371 of the Public Health Service Act (42 U.S.C. § 273) ("Donation Service Area");

B. IOPO is a member of the Organ Procurement and Transplantation Network ("OPTN") established under Section 372 of the Public Health Service Act (42 U.S.C. § 274), the nonprofit corporation composed of transplant centers, organ procurement organizations, and histocompatability laboratories, with the purpose of increasing the availability and access to donor organs;

C. OPTN is administered by the United Network for Organ Sharing ("UNOS"), a nonprofit corporation, which, as the OPTN contractor, manages the national Organ transplant waiting list, manages clinical data in a secure environment, works to improve the quality processes of OPTN, and facilitates the Organ allocation, matching and placement process for human Organ transplants;

D. The purposes of IOPO are to perform and coordinate the identification of donors, the retrieval, procurement, preservation and transportation of Organs for transplantation to work with the OPTN and UNOS in the allocation and placement of Organs available for transplant, and to educate medical personnel and the general public regarding donation and transplantation issues;

E. Hospital participates in the Medicare and Medicaid program and desires to be in compliance with Section 1138 of the Social Security Act (42 U.S.C. § 1329b-8) and the rules of the Centers For Medicare and Medicaid Services ("CMS") for hospital conditions of participation in Medicare and Medicaid programs (42 CFR Part 482.45);

F. Hospital is located within the Donation Service Area of IOPO;

G. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs donated, providing Timely Referral to IOPO of Imminent Deaths and deaths which occur in Hospital; allowing families of Potential Donors to be informed of the potential for Organ, Tissue, or Eye donation; and maintaining Potential Donors under the direction and guidance of IOPO while necessary determinations of medical suitability, testing and placement of Organs can take place. Hospital agrees to cooperate with IOPO in supporting a patient's right to donate Organs, Tissue and Eyes when an appropriate declaration of gift has been made by the patient, even if that declaration of gift is contrary to the wishes of the next of kin, and, allowing IOPO to appropriately approach all families of medically suitable Potential Donors in order to obtain the consent to donate Organs, Tissue and Eyes, when appropriate, for suitable Potential Donors under eighteen years of age or where no declaration of gift can be found. Hospital hereby requests that IOPO recover all Organs from Donors who die within Hospital that are determined to meet the requirements of medical suitability; and

H. In situations where organs, tissue and eyes are determined not to be medically suitable for purposes of human transplantation, Hospital and IOPO agree that with appropriate consents, procurement may proceed for medical or dental education, research, the advancement of medical or dental science, or therapy.

Attachments:

American Donor Services Question Form

Approver	Date
Denise Kaetzel: Director Quality Services	01/2014
Vicki Stuffle: Director Trauma Services	01/2014
Denise Kaetzel: Director Quality Services	01/2014
Michael G. Jones: Chairperson Ethics Committee	01/2014
Ryan Sherer, M.D.: Medical Staff President	01/2014
Tonya Heim: Vice President Patient Services and CNO	01/2014
Ray Snowden: Board Chairperson	01/2014
Vicki Stuffle: Director Trauma Services	12/2015
Ryan Young: Director Emergency Services	12/2015
Denise Kaetzel: Director Quality Services	12/2015
Sr. Rose Mary Rexing: Ethics Committee Chairperson	12/2015
Nicholas Werne, M.D.: Medical Staff President	01/2016
Tonya Heim: Vice President Patient Services and CNO	01/2016
E. Kyle Bennett: President and CEO	02/2016

AMERICAN DONOR SERVICES, INC.

1. **DECEDENTS NAME :**_____
2. **DECEDENTS ADDRESS :**_____
3. **DATE OF BIRTH :**_____
4. **AGE :**_____
5. **RACE :**_____
6. **HEIGHT :**_____ **SOURCE :**_____
7. **WEIGHT :**_____ **SOURCE :**_____
8. **MEDICAL RECORD NUMBER :**_____
9. **DATE AND TIME OF ADMISSION :**_____
10. **PRELIMINARY CAUSE OF DEATH :**_____
11. **PRIMARY/ PRONOUNCING MD :**_____
12. **DATE/ TIME OF DEATH :**_____
13. **EMS SERVICE PROVIDER :**_____
14. **MEDICAL HISTORY :**_____
15. **DAYS ON VENT :**_____
16. **MEDICATIONS :**_____
17. **WBC-DATE AND RESULT :**_____
18. **CHEST X-RAY-DATE AND RESULT :**_____
    _____
19. **CULTURES-DATE AND RESULT :**_____
    _____
20. **TEMPS-DATE AND RESULT :**_____
21. **BLOOD PRODUCTS GIVEN IN THE LAST 48 HOURS-DATE AND TIME :**_____
    _____
22. **COLLOIDS GIVEN IN THE LAST 48 HOURS-DATE AND TIME :**_____
    _____
23. **CRYSTALLOIDS GIVEN 1 HOUR BEFORE DEATH :**_____
    _____
24. **ANTIBIOTIC COVERAGE :**_____
25. **LOCATION OF MEDICAL RECORD :**_____
26. **BODY COOLED- DATE AND TIME :**_____
27. **COOLING METHOD :**_____
28. **CORONER CASE-Y/N...CORONER NAME :**_____
29. **NEXT OF KIN PHONE NUMBER :**_____
30. **NEXT OF KIN ADDRESS :**_____
31. **FUNERAL HOME NAME, PHONE NUMBER, ADDRESS :**_____
    _____

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 19

DIVERSION POLICY

1. Diversion Policy and Completed Spreadsheet

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Effective:	*08/2006*
Reviewed/Approved:	*12/2015*
Last Revised:	*12/2015*
Expires:	*11/2017*
Owner:	*Michele Messmann: Nurse Clinician Emergency Services*
Policy Area:	*Emergency Services*
References:	

Emergency Patient Diversion

PURPOSE:

To provide safe emergency care for patients arriving by ambulance to Memorial Hospital and Health Care Center.

POLICY:

The Emergency Department of Memorial Hospital and Health Care Center attempts to see all patients in a timely fashion. During hours of peak census, patients in the Emergency Department will be informed of the approximate wait time during triage. The need for diversion will be based on exceeding the capabilities or capacities of the emergency department. Diverting ambulance patients will only occur after the hospital has exhausted all internal resources to relieve the precipitating event and after approval from the Administrator On-Call. Prior to calling any level of diversion, the Emergency Department Director and House Supervisor (if after hours) will be notified by the Emergency Department Physician of the situation. Categories of selective diversion will be identified when diversion becomes necessary. These categories include: Full Hospital Diversion (Level I), Emergency Department Diversion (Level II) and Equipment Failure (Level III). This policy does not cover the management of trauma patients by Memorial Ambulance Services.

Level I Diversion:

The Hospital is involved in an internal disaster, i.e. fire, chemical spill, bomb threat, etc.

A. All ambulance patients will be diverted.

B. No direct or straight admissions from other facilities will be accepted.

C. No direct or straight admissions from physician offices will be accepted.

D. Notification of area ambulance services listed below in procedure will occur Inform all ambulance services that no call ahead is needed, the hospital is not accepting any patients at this time.

E. Consider activation of Code Yellow- Emergency Operations Plan and staff recall.

Level II Diversion:

The Emergency Department is at capacity and cannot in good faith accept incoming ambulances. All available resources have been exhausted.

A. Ambulance patients may be diverted with the following exception:

1. Memorial Hospital and Health Care Ambulance Service will NOT be diverted.

B. Notification of ambulance services as listed below in procedure. Inform all outside ambulance services to call ahead on all patients for instruction prior to transport.

Level III Diversion:

No capability to provide diagnostic or screening equipment- i.e. CT scanner is not functioning.

A. All incoming ambulances transporting patients that have either a positive Cincinnati Prehospital Stroke Scale or complaint of stroke like symptoms will be instructed to call to Medical Control prior to departure from scene for instruction.

   1. Medical Control has the authority to determine if diversion to a different facility is in the best interests of the patient.

B. Diversion of trauma patients will occur if meet criteria for Trauma Alert Patient AND air medical transport is not available due to:

   1. Severe Weather
   2. Power lines too close to landing area
   3. Trees, signs, poles, or other obstacles in immediate landing area
   4. Large gatherings of civilians in the area
   5. An expectation that the area may not remain safe

C. In the instance of B, all non-MHHCC ambulances will be diverted to the nearest trauma center. MHHCC ambulances will be instructed to call ahead on all trauma patients prior to transport. Medical Control, in conjunction with the Director of Ambulance Services, will advise whether diversion would be in the best interest of patient. Alternatively, any Ambulance Service can utilize the helipad at Memorial Hospital and Health Care Center for air medical transport with the understanding that the patient is only to have "come to the hospital" if patient condition deteriorates and becomes unstable for transport. If the helicopter is not on the helipad and not in sight on arrival, the patient should be taken to the Emergency Department for additional treatment regardless of the current diversionary status.

D. Any trauma patient that is diverted will be required to be reviewed at the Trauma Peer Review committee meeting to identify appropriateness and opportunities for improvement.

E. For criteria of Trauma Alert Patient, see "Trauma Alert Patient" Assessment Transport and Guidelines

F. While on Level III diversion, at all times MHHCC Ambulance service MUST keep at minimum two ambulances in Dubois County.

G. Notification of Ambulance Services will occur as below. Inform all ambulance services of the type of equipment failure causing the diversion. Instruct all ambulance services to call ahead on all patients prior to transport. EMS agencies will be given an approximate time frame for diversion due to equipment failure.

PROCEDURE:

A. Upon realization of any event(s) which may require diversion activation, the Emergency Department Physician will notify the Emergency Department Director or House Supervisor if after hours. The House Supervisor will notify the Emergency Department Director if after hours. All available resources will be utilized to alleviate the precipitating factors prior to declaring diversionary status. The Emergency

Department Director will then notify the Administrator On-Call, for approval of decision to divert. The Emergency Department Director or House Supervisor if after hours, will then notify the following entities regarding the hospital's diversionary status:

1. President and CEO (if not Administrator On-Call)
2. Director of Ambulance Services
3. Dubois County Dispatch
4. Area Ambulance Services – Martin County, Pike County, Spencer County, Orange County, Crawford County, Southwest (Daviess County), Gibson County, Warrick County, Knox County, and Perry County
5. Director of Trauma Services
6. Emergency Department Medical Director

B. Upon alleviation of the precipitating cause for diversion, the Emergency Department Physician will notify the Emergency Department Director. The Emergency Department Director will notify the Administrator On-Call to make the final decision to end diversion. The Emergency Department Director, or House Supervisor if after hours, will notify all entities as listed in letter A of Procedure.

C. Time diversionary status begins and ends as well as time of notifications to above entities will be tracked by the Emergency Department charge nurse on the Diversion tracking form. Copies of completed form will be sent to the Director of Emergency Services, Director of Ambulance Services, and the Director of Trauma Services.

D. Memorial Hospital and Health Care Center will not be on diversionary status for greater than five percent of the time.

REFERENCES:

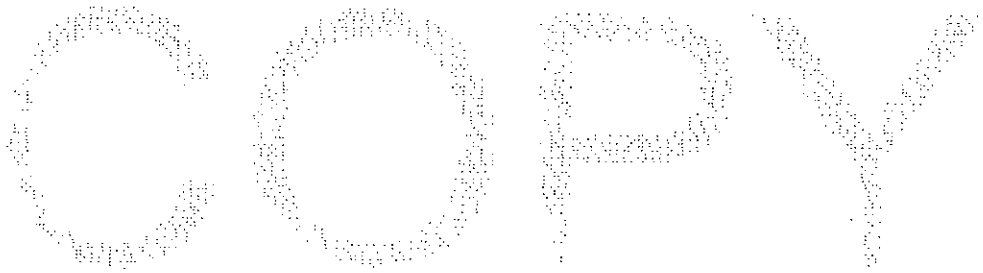
Moffat, J. C. (2015). *The EMTALA answer book* (2015 ed.). New York: Wolters Kluwer.

Committee on Trauma American College of Surgeons. (2014). *Resouces for the optimal care of the injured patient.* American College of Surgeons.

Attachments:

Diversion Worksheet

	Approver	Date
	Lu Wirthwein: Nurse Clinician	10/2012
	Vicki Stuffle: Director Trauma Services	10/2012
	Tonya Heim: Vice President Patient Services and CNO	10/2012
	Lori Leinenbach: Emergency Department Nurse Clinician	10/2014
	Vicki Stuffle: Director Trauma Services	10/2014
	Tonya Heim: Vice President Patient Services and CNO	10/2014
	Lori Leinenbach: Emergency Department Nurse Clinician	10/2015
	Ryan Young: Director Emergency Services	10/2015
	Vicki Stuffle: Director Trauma Services	10/2015
	Suzan Henke: Director Ambulance Services	10/2015
	Stephen DeWitt, D.O.: Medical Director Emergency Services	11/2015
	Donald Vennekotter, M.D.: Medical Director Trauma Services	11/2015
	Marsha Shepherd: Director of Corporate Compliance	11/2015
	Tonya Heim: Vice President Patient Services and CNO [DK]	11/2015
	E. Kyle Bennett: President and CEO	12/2015



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Date_____ **Time**_____ **Level of Diversion**_____

Conditions responsible for divert status:

_____

Resources utilized to alleviate conditions responsible for divert status:

_____

Date ON	Time ON	√	Notification / Communication	√	Date OFF	Time OFF
			Diversion Initiation Declared By: Administrator on Call_____			
			President and CEO_____			
			EMS Medical Director_____			
			EMS Director_____			
			ED Medical Director_____			
			ED Director_____			
			Director of Trauma_____			
			House Supervisor_____			

Agencies notified of Initiation and Termination of Divert Status:

Date ON	Time ON	√	Who was notified	Acute Care Facilities Notification	Who was notified	√	Date OFF	Time OFF
				St. Mary's Medical Center ED (812				
				Deaconess Main Hospital ED (812)				
				Deaconess Gateway Hospital ED (812) 8				
				Good Samaritan Hospital ED (812)				
				Daviess County Hospital ED (812				
				IU Health- Paoli ED (812				
				Perry County Hospital ED (812) !				
				Warrick County Hospital ED (81				

Christ's healing mission of compassion empowers us to be for others through quality and excellence.

Date ON	Time ON	√	Who was notified	Emergency Medical Services Notification	Who was notified	√	Date OFF	Time OFF
				Dubois County Dispatch (812) 4				
				Martin County (812)				
				Pike County (812) 3 (812) 3 5 (alternate)				
				Spencer County (812) (812 (alternate)				
				Orange County (812)				
				Crawford County (812)				
				Southwest (812)				
				Gibson County (812) 96 (812)				
				Warrick County (812) 8				
				Knox County (812)				
				Perry County (812 8 (812) 5 lternate) (81 (alternate)				

Diversion Log				
Date	**Time on**	**Time off**	**Total Time on Diversion**	**Reason:**
June 1, 2015 thru July 7, 2016	*0*		*0*	*No hospital diversions in 12 months for Memorial Hospital and Health Care*
				Center, Jasper, IN

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 20

OPERATIONAL PROCESS PERFORMANCE IMPROVEMENT COMMITTEE

1. Signed Letter from TMD and TPD Committee Membership and Meeting Frequency
2. Operational Attendance Spreadsheet with 12 Months of Data
3. All Trauma Surgeons and Liaisons Attend 2 Meetings Prior to Application Submission

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Performance Improvement and Patient Safety Program (PIPS)

Trauma Program Operational Process Performance Committee

Chair: Trauma Medical Director

Members: Multidisciplinary-Hospital and Medical staff members (see Attendance Sheet for committee members).

Purpose: Addresses, assesses, and corrects global trauma program and system issues.

Frequency of meeting: Monthly with a minimum of 10 meetings per year.

- Handles process
- Includes all program-related services
- Meets regularly
- Takes attendance
- Has minutes
- Works to correct overall program deficiencies to continue to optimize patient care

Trauma Medical Director

7/20/18
Date

Vicki Stuffle
Trauma Program Director

7/17/15
Date

*X=present; A=absent; *=not committee at this time* *Memorial Hospital and Health Care Center - Operational Process Performance Committee Meetings Log*

Operational Process Performance Committee Member Name	Specialty Represented	5/27/2015	7/22/2015	8/26/2015	9/30/2015	10/28/2015	12/9/2015	1/27/2016	2/29/2016	3/23/2016	5/25/2016	7/28/2016	Overall Attendance	Overall Attendance Percentage
Allen, Doris	Radiology	X	X	X	X	X	X	X	X	X	X		10	100%
Anders, Kaye	Finance	X	X	X	X	A	X	A	X	X	X		8	80%
Bennett, Kyle	Administration	A	X	X	X	A	X	X	A	X	X		7	70%
Breitweiser, Christy	Surgery	X	X	X	X	X	X	X	X	X	X		10	100%
Burton, Kathleen	Critical Care	X	X	X	X	*	*	*	*	*	*		4	40%
Clark, Ashli	Rehabilitation	X	X	X	X	X	X	X	X	X	X		10	100%
Clauss, Kelly	Administration	*	*	*	*	A	A	X	A	A	A		1	10%
Faulkner, Phillip	Pastoral Care	X	X	X	X	X	X	X	X	X	X		10	100%
Giesler, Deborah	Social Work	A	A	A	A	A	A	A	A	A	A		0	0%
Greener, Rachelle	Quality	A	A	A	A	A	A	A	A	A	A		0	0%
Gress, Diane	Surgery	A	X	X	A	X	X	X	X	X	X		8	80%
Hamm, Janet	Fianance	X	X	X	A	X	X	X	X	X	X		9	90%
Hammond, Marny	Rehabilitation	X	A	X	A	X	X	X	X	X	X		8	80%
Head, Elizabeth	Anesthesia	X	X	A	A	A	A	A	X	A	A		3	30%
Heim, Tonya	Administration	X	A	X	X	FMLA	FMLA	X	X	X	X		7	70%
Henke, Suzan	Ambulance	X	A	X	X	X	X	X	X	X	X		9	90%
Hopf, Jessica	Pharmacy	A	A	A	A	A	A	A	A	A	A		0	0%
Kemker, Bernard	Surgeon	*	*	*	*	*	*	*	*	X	X		2	100%
Kemp, Andrea	Finance	X	A	X	X	A	X	X	X	X	X		8	80%
Kendall, Pheobe	Emergency	X	A	X	X	X	X	A	X	X	X		8	80%
Kurucz, Marcus	Surgeon	*	*	*	*	*	*	*	*	X	X		2	100%
Lehmkuhler, William	Critical Care	*	*	*	*	*	*	*	*	X	X		2	100%
Leinenbach, Lori	Emergency	X	X	A	X	*	*	*	*	*	*		4	40%
Leinenbach, Sarah	Laboratory/BB	X	X	X	A	A	A	X	X	FMLA	FMLA		5	50%
Lenahan, Cassie (Eckerle)	Critical Care	X	*	*	*	*	*	*	*	*	*		2	20%
McCord, Donna	***Registrar***	X	A	X	X	X	X	X	X	X	X		9	90%
Miller, Thomas	Ambulance	X	A	X	X	A	X	A	X	X	X		7	70%
Mitchell, Dave	Ambulance	X	X	X	X	A	X	*	*	*	*		5	50%
Powell, Melanie	Marketing	A	A	A	X	A	X	A	A	A	X		3	30%
Rose, Michele	Credentialing	X	A	X	A	A	X	X	X	X	X		7	70%
Rowe, Genevia	Respiratory	*	*	*	*	A	A	A	A	A	X		1	10%
Rucker, Jamie	Anesthesia	*	*	*	*	*	X	X	A	X	X		4	40%
Russell, Randall	Finance	X	X	X	A	X	X	X	A	X	X		8	80%
Sample, Stephen	Emergency	*	X	X	A	A	X	X	A	X	X		6	60%

Starling, Cindy	Critical Care	*	*	*	*	X	X	X	X	X	X		6	60%
Stuffle, Vicki	*Trauma Program Director*	X	X	X	X	X	X	X	X	X	X		100	100%
Sturt, Patty	Emergency	X	*	*	*	*	*	*	*	*	*		1	10%
Terwiske, Mallory	Critical Care	*	*	*	*	X	X	X	X	X	X		6	60%
Todd, Patrick	Disaster Prep	A	A	X	A	A	X	X	A	X	X		5	50%
Tollett, Charles	Surgeon	*	*	*	*	*	*	*	*	X	X		2	100%
Vennekotter, Donald	*Trauma Medical Director*	X	X	X	X	X	X	X	X	X	X		10	100%
Wallhauser, Jan	Risk Management	*	A	X	A	X	X	X	X	X	X		7	70%
Wells, Zerrick	Ambulance	*	*	*	*	*	X	X	A	X	X		4	40%
Willegal, Sr. Kate	Post Surgical	*	*	*	*	X	X	X	X	X	X		6	60%
Woebkenberg, Brian	Ortho	X	A	X	X	A	X	X	A	X	X		7	70%
Wright, Jessica	House Supervision	X	X	*	*	*	*	*	*	*	*		2	20%
Young, Ryan	Emergency	*	*	X	X	X	X	X	X	X	X		8	80%
Young, Tricia	Radiology	X	X	X	A	X	X	X	X	A	X		8	80%

10

1. Please place total number of Operational Process Performance Committee meetings held in 823 here.
2. Place all meeting dates in columns C2 through N2, using only the number of columns appropriate for your facility and deleting excess columns. (i.e. if you only had quarterly meetings, then enter dates in C2 through F2)
3. Then list all committee members in column A with their attendance recorded in appropriate columns.
4. The overall attendance will automatically calculate in column O and overall percentage in column P.

X = present **A = absent**

*** = not on the committee at this time**

823

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 21

TRAUMA PEER MORBIDITY AND MORTALITY COMMITTEE

1. Signed Letter from TMD and TPD Committee Membership and Meeting Frequency
2. Peer Attendance Spreadsheet with 12 Months of Data
3. All Trauma Surgeons and Liaisons Attend 2 Meetings Prior to Application Submission

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Performance Improvement and Patient Safety Program (PIPS)

Trauma Multidisciplinary Peer Review Committee

Chair: Trauma Medical Director or designee

Members: General surgeons on trauma call

Orthopedic surgeon liaison

Emergency Medicine physician liaison

Anesthesiologist liaison

Trauma Program Director

Purpose: To improve trauma care by reviewing transfers, deaths, complications, and sentinel events with objective identification of issues and appropriate responses.

Member Requirement: Must attend 50% of meetings

Frequency of meeting: Monthly with a minimum of 10 meetings per year

Evidence for appropriate participation and acceptable attendance must be documented

- TMD must ensure and document dissemination of information and findings from the peer review meetings to all general surgeons

Trauma Medical Director

7/20/15

Date

Vicki Stuffle

Trauma Program Director

7/17/15

Date

Trauma Peer Review Committee Meetings Log

Trauma Peer Review Committee Member Name	Specialty Represented	8/26/2015	9/30/2015	10/28/2015	12/9/2015	1/27/2016	2/29/2016	3/23/2016	5/1/2016	6/1/2016	7/7/2016	Overall Attendance	Overall Attendance Percentage
KEMKER, BERNARD	*GENERAL SURGEON*									X	X	2	20%
KURUCZ, MARCUS	GENERAL SURGEON								X	X		2	20%
LEHMKUHLER, WILLIAM	CRITICAL CARE								X	X	X	3	30%
RUCKER, JAMIE	ANESTHESIA				X	X		X	X	X	X	6	60%
SAMPLE, STEPHEN	EMERGENCY	X			X	X		X	X			5	50%
STUFFLE, VICKI	TRAUMA PROGRAM DIRECTOR	X	X	X	X	X	X	X	X	X	X	10	100%
TOLLETT, CHARLES	GENERAL SURGEON									X	X	2	20%
VENNEKOTTER, DONALD	TRAUMA MEDICAL DIRECTOR	X	X	X	X	X	X	X	X	X	X	10	100%
WOEBKENBERG, BRIAN	ORTHOPAEDICS	X	X		X	X		X	X			6	60%

Total Number of Trauma Peer Review Committee meetings held last year: 10

1. Please place total number of Trauma peer Review Committee meetings held in B23 field.
2. Place all meeting dates in columns C2 through N2, using only the number of columns appropriate for your facility and deleting excess columns . (i.e. if you only had quarterly meetings, then enter dates in C2 through F2)
3. Then list all committee members in column A with their attendance recorded in appropriate columns.
4. The overall attendance will automatically calculate in column O and overall percentage in column P.

23

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 22

NURSE CREDENTIALING REQUIREMENTS

1. Guideline Outlining Credentialing Requirements for ED and ICU Nurses
2. Percentage of Nurses who have Completed Credentialing Requirements for ED and ICU

Memorial Hospital and Health Care Center

22. Nurse Credentialing Requirements

All new staff receive web based education concerning trauma during their orientation. Then Emergency Department (ED) and Critical Care Nurses receive more specific trauma education from their preceptor while during their orientation on the specific unit.

Competencies are held yearly that are specific to the Unit's based population. This education includes the specifics of care for a trauma patient in their unit.

Emergency Department Nurses required education:

1. BLS
2. ACLS (within one year of hire)
3. Dysrhythmia Course completion
4. TNCC (within 2 years of hire)
5. ENPC (within 2 years of hire)
6. NIHSS
7. Triage Course (after 6 months ED experience)

ED Suggested education:

1. PALS
2. ATCN
3. TCAR/PCAR
4. Crucial Conversations
5. HeartMath

Critical Care Nurses required education:

1. BLS (within 30 days of hire)
2. Dysrhythmia course
3. ACLS (within one year of hire)
4. 12 Lead interpretation (within one year of hire)
5. 4 hours of trauma education per year (obtained through Trauma Skills Days; Society of Trauma Nurses Trauma Lecture Series, etc.)

Critical Care Nurses suggested education:

1. TNCC
2. TCAR
3. Crucial Conversations
4. HeartMath

Certification is encouraged for all nursing staff.

Trauma Lecture is included in our curriculum for our new nurse Onboarding Program. All new nurses are required to attend the education. The lecture is 4 hours in length covering basic and specific trauma information.

Job Description

RN - BSN - 6230.05.798
Emergency Services - 6230

Job Summary
Under general supervision, renders nursing care to patients within assigned department and demonstrates knowledge of developmental needs of patient population specific to that department. (Patient population is defined in each department's Scope of Practice.) May direct the activities of the department or a specific work group for a shift to include assigning duties to professional or non-professional personnel, overseeing and evaluating work performance of other personnel, and assisting in orientation of personnel. May assume responsibilities of Charge Nurse when deemed capable by the Department Director.

Qualifications
Education:
BSN required. Graduate from an accredited school of nursing preferred with current registration in Indiana required. Advanced preparation for specialized areas preferred.

Training:
Individualized preceptor training four to eight weeks. May be more or less at discretion of Director. Successful completion of orientation skills checklist. CPR Provider-C required within 30 days of hire. ACLS (within one year) required for Emergency Services. TNCC and ENPC (within two years) required for Emergency Services. Specialty certification recommended for all staff nurses.

Experience:
None required. Previous experience as a Registered Nurse in a health care facility preferred.

Job Knowledge, Skills, and Abilities:
Knowledge and skills which enable the assumption of responsibility for the nature and quality of nursing care rendered to patients. Thorough knowledge of nursing theory and practice. Familiarity with organization, functions, policies and procedures of the Hospital as they relate to Patient Services. Knowledge of the value of rehabilitation concept in promotion of mental and physical health. Completion of basic skills checklist within 60 days. Thorough knowledge of the anatomy, physiology, and complications of ill and injured individuals who present to the Emergency Department for evaluation and treatment. Provides nursing care to patients with non-urgent to emergent medical needs. Provides appropriate management of injuries, poisonings, and medical and traumatic emergencies in children and adults. Provides appropriate assistance for special procedures performed in the department. Focuses on the cyclic process of recovery beginning with education of prevention to rehabilitation. Competency validation is completed by the Department Director or designee on an individual basis according to previous experience and abilities; but not to exceed six months from orientation to completion. Provides education for the patient addressing the educational needs that have been identified.

Performance Requirements

Responsibility for:

Accurately assesses, plans, implements, and evaluates patient care. Documents and maintains accurate and complete nursing records. Supervises implementation of physician orders. Assists in teaching patients and providing staff education. Maintains a safe and clean environment. Maintains supplies in a cost effective manner. Maintains patient safety and comfort, Infection Control, and Standard Precautions.

Physical Demands:

On feet for major portion of the day. Much pulling, pushing, and lifting required. Visual, auditory, and speech acuity essential to supervising nursing care and evaluating patients need. Works in nursing department and patient rooms which are well lighted, heated, and ventilated with some exposure to disagreeable conditions. May come in contact with hazardous health conditions; however, if proper procedure is followed no harm should come to employee.

Special Demands:

Reflects the mission, philosophy, core values, and customer service plan of Memorial Hospital and Health Care Center in action and attitude. Nurses are encouraged to be actively involved in the community as leaders in health and wellness promotion and injury and disease prevention. Nursing practice reflects the American Nurse Association Code of Ethics. Willingness to work with realization that errors and incompetence may have serious consequences for patients. Competency, tact, and patience are necessary when communicating with patients, families, physicians, and other personnel. Utilizes initiative and judgment in adapting or devising techniques and procedures to meet the needs of the nursing department. Maintains confidentiality. May be required to work rotating shifts and a reasonable amount of overtime.

Representative Functions

Ongoing Practices the Core Values of Memorial Hospital and Health Care Center and adheres to the 5-Step Customer Service Plan.

1. Utilization of the Nursing Process/QA/PI. (15%)
- Assesses patients within departmental time frame as evidenced by accurate and complete documentation.
- Develops individualized plan of care addressing nursing diagnosis, goals, interventions, and/or nursing protocols within established department guidelines.
- Address discharge planning needs, patient involvement, and interdisciplinary collaboration as evidenced in documentation.
- Implements and accurately completes patient care assignments within length of shift, based on acuity and as evidenced by documentation.
- Evaluates patient responses to nursing interventions and progression toward goals as evidenced in documentation.
- Participates in QA/PI data collection as evidenced by verbal or written input.

2. Safety/Emergency Procedures. (15%)
- Demonstrates knowledge of safety and emergency procedures, responsibility in all code situations, and evacuation plans for specific departments as documented on Competency Skills Checklist.
- Demonstrates knowledge of providing for patient safety in use of siderails, restraints, and proper identification according to department policy as evidenced by observation.
- Demonstrates knowledge of infection control and Standard Precautions guidelines as

evidenced by observation.

3. Delivery of Patient Care. (35%)
- Prepares and administers medication according to established Hospital policies and procedures as evidenced by observation and documentation.
- Completes department based Competency Skills Checklist as evidenced by documentation.
- Compassionately gives personal patient care to provide comfort and well-being to the patient, acknowledging physiological and psychosocial needs as evidenced by personal satisfaction.
- Demonstrates appropriate management of eye injuries; i.e., obtain visual acuity, and perform eye irrigation as needed as evidenced by observation and documentation.
- Demonstrates the appropriate management of a victim of a sex crime; i.e., obtain history, documentation of legal aspects, collection of evidence and specimens, disposition of patient, and notification of authorities as evidenced by observation and documentation.
- Demonstrates appropriate management of the abuse victim, adult, or child; i.e., collection of evidence, documentation of legal aspects, disposition of patient, and notification of authorities as evidenced by observation and documentation.
- Demonstrates appropriate management of the patient with drug overdose and/or poisoning; i.e., notification of Poison Control Center, notification of authorities, follow-up care, and counseling as evidenced by observation and documentation.
- Demonstrates appropriate management of pediatric emergencies; i.e., use of pediatric code bag and drugs as evidenced by observation and documentation.
- Demonstrates appropriate management of the cardiac patient; i.e., establish and maintain airway and breathing, monitor cardiovascular system, follow cardiac protocols, prepare patient for cardiac intervention (Cath Lab), and TNKase protocol as evidenced by observation and documentation.
- Demonstrates appropriate management of the trauma patient; i.e., perform primary and secondary survey, establish and maintain airway and breathing, maintain hemodynamics, follow trauma protocols, monitor cardiovascular system, and use of trauma equipment as evidenced by observation and documentation.
- Demonstrates appropriate management of the burn patient; i.e., establish and maintain airway, breathing, and circulation; calculate and provide fluid replacement; and prepare for transfer as needed as evidenced by observation and documentation.
- Demonstrates appropriate management of the patient with laceration; i.e., perform wound cleansing, obtain tetanus history, and document description of laceration and neurological status as evidenced by observation and documentation.
- Demonstrates appropriate management of the patient with fracture; i.e., immobilize affected area, document injury and neurological status as evidenced by observation and documentation.
- Demonstrates appropriate management of the patient with amputation; i.e., maintain cardiovascular status, care for the amputated part, and prepare for possible transfer as evidenced by observation and documentation.
- Demonstrates appropriate assistance with special procedures in the Emergency Department; i.e., placement of central lines, pacemakers, arterial lines, chest tubes, cricothyroidotomy, pericardiocentesis, peritoneal lavage, intubation, tracheostomy, cardioversion, and needle thoracostomy as evidenced by observation and documentation.
- Demonstrates appropriate triage of patients that present to the Emergency Department for evaluation and treatment as evidenced by observation and documentation.

- Demonstrates ability to provide education for the Emergency Services patient as evidenced through documentation and observation.

4. Equipment Utilization/Care of Equipment. (10%)
- Utilizes Hospital and department specific equipment correctly and appropriately as evidenced by the performance, observation, and Competency Skills Checklist.
- Maintains emergency equipment in operational mode as evidenced by equipment checklist.
- Maintains a clean, neat, and safe environment for patients and staff according to the Hospital and unit policies as evidenced by observation and satisfaction of others.

5. Multidisciplinary Utilization. (10%)
- Accurately reports pertinent information to the oncoming shift/nursing director/nursing supervisor as evidenced by personal observation.
- Informs the patient's physician of changes in patient condition, accurately relays information, and appropriately charts any changes in medical record.
- Assures continuity of care through accurate and effective communication when transferring patients as evidenced by observation and documentation and expressed satisfaction of others.
- Coordinates patient care with ancillary departments and community resources as evidenced by documentation and expressed satisfaction of others.
- Follows policies and rules in the Corporate Compliance Manual and complies with all Federal, State, and local laws applicable to this position.
- Provides leadership in the community by involvement in activities to promote health and wellness through volunteer time, education, and/or resources.

6. Professional Growth/Continuing Education. (15%)
- Attends and participates in 67% of assigned committee meetings as evidenced by documentation.
- Attends a minimum of six inservices (other than mandatory inservices) in a year as evidenced by documentation of attendance.
- Functions effectively as charge nurse as evidenced by completion of charge nurse's Competency Skills Checklist and satisfaction of others.
- Encourages nurturing of new nurses and student nurses as evidenced by employee and instructor feedback.

Acknowledgement

I have read my assigned job description and have applied my signature to this form. I understand that entry of my unique user ID number and password will have the same effect as my written signature.

APPROVED BY:	Director of ED and House Supervision	DATE:
APPROVED BY:	Vice President of Patient Services and CNO	DATE:

Job Description

RN – BSN – 6120.05.798
Critical Care Services - 6120

Job Summary
Under general supervision, renders nursing care to patients within assigned department and demonstrates knowledge of developmental needs of patient population specific to that department. (Patient population is defined in each department's Scope of Practice.) May direct the activities of the department or a specific work group for a shift to include assigning duties to professional or non-professional personnel, overseeing and evaluating work performance of other personnel, and assisting in orientation of personnel. May assume responsibilities of Charge Nurse when deemed capable by the Department Director or Clinical Manager.

Qualifications
Education:
BSN required. Graduate from an accredited school of nursing preferred with current registration in Indiana required. Advanced preparation for specialized areas preferred.

Training:
Individualized preceptor training four to twelve weeks. May be more or less at discretion of Director. Successful completion of orientation skills checklist. Healthcare Provider CPR course is required within 30 days of hire. ACLS and 12 lead EKG interpretation required within one year. Trauma Nurse Core Course (TNCC) or Trauma Care After Resusciation (TCAR) recommended. Specialty certification recommended for all staff nurses.

Experience:
None required. Previous experience as a Registered Nurse in a health care facility preferred.

Job Knowledge, Skills, and Abilities:
Knowledge and skills which enable the assumption of responsibility for the nature and quality of nursing care rendered to patients. Thorough knowledge of nursing theory and practice. Familiarity with organization, functions, policies and procedures of Hospital as they relate to Patient Services. Knowledge of the value of rehabilitation concept in promotion of mental and physical health. Completion of basic skills checklist within 120 days.

Thorough knowledge of anatomy, physiology, and complications of disease process of critically ill and cardiac monitored patients throughout the life span. Provides nursing care to patients with invasive lines requiring hemodynamic monitoring and mechanical ventilation. Cares for patients requiring titration of vasoactive medications, electrical cardioversion procedures, post-operative surgical care, and special procedures. Provides patient and family education of disease processes, modalities of treatments, and other needs exhibited by the patient and/or family members. Referrals for information/patient education are made to the appropriate people if nursing cannot fulfill these needs. Competency validation is completed by the Department Director or designee on an

individual basis according to previous experience and abilities. Provides education for the patient addressing the educational needs that have been identified.

Performance Requirements

Responsibility for:

Accurately assesses, plans, implements, and evaluates patient care. Documents and maintains accurate and complete nursing records. Supervises implementation of physician orders. Assists with patient and staff education. Maintains a safe and clean environment. Maintains supplies in a cost effective manner. Maintains patient safety and comfort, Infection Control, and Standard Precautions.

Physical Demands:

On feet for major portion of the day. Much pulling, pushing, and lifting required. Visual, auditory, and speech acuity essential to supervising nursing care and evaluating patients need. Works in nursing department and patient rooms which are well lighted, heated, and ventilated with some exposure to disagreeable conditions. May come in contact with hazardous health conditions; however, if proper procedure is followed no harm should come to employee.

Special Demands:

Reflects the mission, philosophy, core values, and customer service plan of Memorial Hospital and Health Care Center in action and attitude. Nurses are encouraged to be actively involved in the community as leaders in health and wellness promotion and injury and disease prevention. Nursing practice reflects the American Nurse Associates Code of Ethics. Willingness to work with realization that errors and incompetence may have serious consequences for patients. Competency, tact, and patience are necessary when communicating with patients, families, physicians, and other personnel. Utilizes initiative and judgment in adapting or devising techniques and procedures to meet the needs of the nursing department. Maintains confidentiality. May be required to work rotating shifts and a reasonable amount of overtime.

Representative Functions

Ongoing Practices the Core Values of Memorial Hospital and Health Care Center and adheres to the 5-Step Customer Service Program.

1. Utilization of the Nursing Process/QA/PI. (10%)
- Assesses patients within departmental time frame as evidenced by accurate and complete documentation.
- Develops individualized plan of care addressing nursing diagnosis, goals, interventions, and/or nursing protocols within established department guidelines.
- Address discharge planning needs, patient involvement, and interdisciplinary collaboration as evidenced in documentation.
- Implements and accurately completes patient care assignments within length of shift, based on acuity and as evidenced by documentation.
- Evaluates patient responses to nursing interventions and progression toward goals as evidenced in documentation.
- Participates in QA/PI data collection as evidenced by verbal or written input.

2. Safety/Emergency Procedures. (15%)
- Demonstrates knowledge of safety and emergency procedures, responsibility in all code situations, and evacuation plans for specific departments as evidenced by documentation and observation.
- Demonstrates knowledge of providing for patient safety in use of siderails, restraints, and proper identification according to department policy as evidenced by observation.
- Demonstrates knowledge of infection control and Standard Precautions guidelines as evidenced by observation.

3. Delivery of Patient Care. (40%)
- Prepares and administers medication according to established Hospital policies and procedures as evidenced by observation and documentation.
- Completes department based Competency Skills Checklist as evidenced by documentation.
- Compassionately gives personal patient care to provide comfort and well-being to the patient, acknowledging physiologically and psychosocial needs as evidenced by personal satisfaction.
- Demonstrates the ability to correctly interpret cardiac dysrhythmias as evidenced by completion of annual ECG Interpretation Competency test with a 100% score.
- Demonstrates the knowledge of the appropriate care of the patient during a cardiac/respiratory arrest as evidenced by documentation and observation.
- Demonstrates the ability to operate patient assessment and monitoring equipment used in the Critical Care Services Department as evidenced by observation.
- Demonstrates the knowledge to administer medications only given in the Critical Care Services Department as evidenced by observation and documentation.
- Demonstrates the knowledge to care for patients pre and post procedure of percutaneous coronary intervention and percutaneous peripheral vascular intervention.
- Demonstrates the ability to care for the needs of the trauma patient.
- Demonstrates ability to provide education for the Critical Care Services patient as evidenced through documentation and observation.

(Intensive Care Only)
- Demonstrates the knowledge to assist the physician in placing invasive lines, maintaining these lines, and continuous hemodynamic monitoring as evidenced by observation and documentation or successful completion of a summation of these procedures.
- Demonstrates the knowledge to manage a patient requiring mechanical ventilation and assisting a physician with endotracheal intubation as evidenced by observation and documentation.
- Demonstrates the knowledge to assist a physician with pericardiocentesis as evidenced by observation or successful completion of simulation of this procedure.
- Demonstrates the knowledge to care for a patient on an IABP as evidenced by observation or successful completion of simulation.

4. Equipment Utilization/Care of Equipment. (10%)
- Utilizes Hospital and department specific equipment correctly and appropriately as evidenced by observation.
- Maintains emergency equipment in operational mode as evidenced by observation.

- Maintains a clean, neat, and safe environment for patients and staff according to the Hospital and unit policies as evidenced by observation and satisfaction of others.

5. Multidisciplinary Utilization. (10%)
- Accurately reports pertinent information to the oncoming shift/nursing director/nursing supervisor as evidenced by observation.
- Informs the patient's physician of changes in patient condition, accurately relays information, and appropriately charts any changes in medical record as evidenced by documentation and observation..
- Assures continuity of care through accurate and effective communication when transferring patients as evidenced by observation, documentation and expressed satisfaction of others.
- Coordinates patient care with ancillary departments and community resources as evidenced by documentation and expressed satisfaction of others.
- Follows policies and rules in the Corporate Compliance Manual and complies with all Federal, State, and local laws applicable to this position.
- Provides leadership in the community by involvement in activities to promote health and wellness through volunteer time, education, and/or wellness.

6. Professional Growth/Continuing Education. (15%)
- Attends a minimum of six inservices (other than mandatory inservices) in a year as evidenced by documentation of attendance.
- Must attend 4 hours of trauma education per year.
- Functions effectively as charge nurse as evidenced by documentation and satisfaction of others, if applicable.
- Encourages nurturing of new nurses and student nurses as evidenced by employee and instructor feedback.

Acknowledgement

I have read my assigned job description and have applied my signature to this form. I understand that entry of my unique user ID number and password will have the same effect as my written signature.

APPROVED BY:	Director of Critical Care Services	DATE:
APPROVED BY:	Vice President of Patient Services and CNO	DATE:

2016	DEGREE	CEN	ACLS-Q1	ACLS-Q2	ACLS-Q3	ACLS-Q4	ENPC-FEB	ENPC-OCT	TNCC-MAR	TNCC-NOV	PALS-Q1	PALS-Q2	PALS-Q3	BLS	NIHSS	TRIAGE	Crucial Conversations	HeartMa
Atkins, Melissa	ASN - In School				9/17			10/19	3/20						X			
Benham, Kelli	ASN-In School 4/2017		1/17					DUE	3/20				10/17	1/17	X			
Burton, Brent	ASN - In School		1/17				2/20			11/18				1/18	X			
Campbell,Samantha	BSN		3/18				2/19		3/19					X	X	X		
Coomer,Maggie	ASN		3/17				2/18			11/17				X	X	X		
Daniel, Lori	BSN - In School	SANE				12/16		DUE		DUE	3/17			4/17	X	X		
Dick, Kaitlyn														5/18	X	X		
Dittmer, Casey	BSN				9/16		2/17		3/20				10/16	X	X			
Gress, Micki	BSN	8/17				10/16	2/17			11/17				5/17	X	X	X	
Griffith, Darla	ASN			6/17				10/19	3/20		3/17			X	X	X		
Haulk, Cindi	BSN	CEN			9/17		2/17		3/17			6/18		X	X	X		
Hewitt,Ben	ASN				9/16		2/20		3/17					7/17	X	X		
Hochgesang, Derek	ASN - In School					12/16	2/19		3/19					1/18	X			
Hopf, Doris	ASN		3/18				2/20		3/18					4/18	X	X	X	
Hopster, Cheryl	BSN				9/16		2/18			DUE				6/18	X	X		
Kendall, Pheobe	ASN - In School	12/17				12/16		DUE	IN	11/19				12-16	X	X	X	X
Livingston,Sharon	ASN		3/18					10/18		11/18		4/18		9/17	X	X		
Martin, Susan	BSN	4/18		6/17			2/18		IN	IN				9/16	X	X	X	
McCord, Donna	BSN	MAY 2020	3/18				IN	IN	IN	IN				X	X	X		X
Mehringer,Tonia	BSN		3/18					10/18		11/18			10/17	9/16	X	X		
Messman,Michele	BSN						IN	IN	3/18	IN				X	X	X	X	X
Miller,Hannah														X	X			
Rogier, Marc														X	X			
Royal, Alyssa	ASN - In School							?		?				X	X			
Schipp,Jessica														X	X			
Seng,Mariah														X	X			
Sitzman,Sara	BSN	CEN	3/18				2/19		3/20					X	X	X		X
Snell,Erica	ASN		3/18				2/17		3/17		3/18			X	X	X	X	
Walton, Kelly			X				X		X					X	X	X		
Wintergerst, Adam		CEN	X				X		X					X	X	X		
Young, Ryan	BSN	CEN	X				Instructor		instructor					X	X	X		X
Percentages	12/31=39% BSN	11/31=35% CEN	25/31+81% ACLS				25/31=81% ENPC		25/31=81% TNCC			8/31=26% PALS		100% BLS	100% NIHSS	84% Triage		

Stuffle, Vicki L

From: Stuffle, Vicki L
Sent: Thursday, July 14, 2016 10:21 AM
To: Stuffle, Vicki L
Subject: FW: ACLS/BLS percentages for Trauma

From: Steffe, Ann M.
Sent: Thursday, July 14, 2016 10:08 AM
To: Stuffle, Vicki L; Steffe, Ann M.
Cc: Starling, Cindy; Nichter, Brooke N
Subject: RE: ACLS/BLS percentages for Trauma

Vicki,
A new hire, Kristi Kingsley has TNCC too.

Thanks

Ann Steffe MSN, RN, PCCN
Director of Critical Care Services
Memorial Hospital and Health Care Center
800 West 9th Street
Jasper, Indiana 47546
Office
Fax

MEMORIAL HOSPITAL
And Health Care Center
Christ's healing mission of compassion empowers us to be for others through quality and excellence.

From: Steffe, Ann M.
Sent: Thursday, July 14, 2016 7:40 AM
To: Stuffle, Vicki L
Cc: Starling, Cindy; Steffe, Ann M.; Nichter, Brooke N
Subject: RE: ACLS/BLS percentages for Trauma

Vicki,
CCS staff is 100% BLS Certified and 98% (49/50) ACLS Certified. We will be a 100% ACLS after the September class.

TNCC – Brooke, Rhonda Glispie, Kristi Kingsley and Jen Bayer = 8%
TCAR – Cindy, Brooke and Mallory = 6%

Jen Bayer also has – ITLS and ATLS

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APPLICATION FOR "IN THE PROCESS" LEVEL III TRAUMA CENTER

SECTION 23

COMMITMENT BY THE GOVERNING BODY AND MEDICAL STAFF

1. Written Statements Signed by Governing Body and Medical Staff Representative

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July 14, 2016

WHEREAS, Memorial Hospital and Health Care Center supports the establishment of a Level III Adult Trauma Center.

NOW THEREFORE, after motion made, duly seconded, and unanimously carried, the following resolution is hereby adopted and approved:

BE IT RESOLVED, that the Board of Directors of Memorial Hospital and Health Care Center approves the establishment of a Level III trauma center. The Board commits to maintain the high standards needed to provide optimal care of all trauma patients. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions.

FURTHERMORE, the Board commits to pursue the verification by the ACS within one (1) year of application submittal. The Board is committed that Memorial Hospital and Health Care Center will achieve verification by the ACS of Level III Trauma Center within two (2) years of the granting of "in the ACS verification process" status. The Board acknowledges that if Memorial Hospital and Health Care Center fails to pursue verification within one (1) year of application and/or does not achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status that the hospital's "in the ACS verification process" status will be immediately revoked and become null and void.

Mr. Raymond Snowden, Board Chairperson

Sr. Renée Cunningham LCM

Sr. Renée Cunningham, LCM, Board Secretary

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July 14, 2016

WHEREAS, Memorial Hospital and Health Care Center supports the establishment of a Level III Adult Trauma Center.

NOW THEREFORE, after motion made, duly seconded, and unanimously carried, the following resolution is hereby adopted and approved:

BE IT RESOLVED, that the Medical Staff of Memorial Hospital and Health Care Center approves the establishment of a Level III trauma center. The Medical Staff commits to maintain the high standards needed to provide optimal care of all trauma patients. The multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions.

FURTHERMORE, the Medical Staff commits to pursue the verification by the ACS within one (1) year of application submittal. The Medical Staff is committed that Memorial Hospital and Health Care Center will achieve verification by the ACS of Level III Trauma Center within two (2) years of the granting of "in the ACS verification process" status. The Medical Staff acknowledges that if Memorial Hospital and Health Care Center fails to pursue verification within one (1) year of application and/or does not achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status that the hospital's "in the ACS verification process" status will be immediately revoked and become null and void.

Dr. Nicholas Werne, Medical Staff President